

Infection Prevention Strategy

1 April 2019

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Agenda Item No: 11.4

Trust Board	
Meeting Date:	1 April 2019
Title:	Infection Prevention Strategy 2019-2022
Purpose of the Report:	Recommend to Trust Board to approve
Summary:	<p>The overall aim of this strategy is to deliver harm free care for those accessing NHS or commissioned health care in Wolverhampton. It is aimed at supporting 3 domains of the NHS outcomes framework:</p> <ul style="list-style-type: none"> • Preventing people from dying prematurely • Ensuring that people have a positive experience of healthcare • Treating and caring for people in a safe environment and protecting them from avoidable harm. <p>The strategy will provide an overview of the risks, costs and benefits associated with the prevention and control of infection in Wolverhampton including The Royal Wolverhampton NHS Trust (RWT), independent contractors of health and social care contracted to Wolverhampton Clinical Commissioning Group (WCCG) or Wolverhampton City Council (WCC) and the wider Wolverhampton health and social care community and taking a view on nationally and internationally identified risks. It will be considerate of emerging and unknown organisms and infections which may arise, of national priorities and drivers and of the information communication and technological revolution. It will therefore ensure that systematic review of existing and future working practices are highly efficient and are integrated into a safe governance infrastructure with effective surveillance data and its analysis at its core along with excellent systems of communication.</p>
Recommendation:	To approve the renewed strategy.
Action required:	Approve
Clinical implications and view	Shared for consultation at Infection Prevention and Control Group, approved by Wolverhampton City Council Commissioning Group.
Patient, carer, public impact and views	Shared for consultation at Infection Prevention and Control Group where there is patient representation.
Resource implications	No additional resources required as a result of the strategy review and renewal.
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CQC Domains	<p>Safe: patients, staff and the public are protected from abuse and avoidable harm.</p> <p>Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.</p> <p>Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.</p> <p>Responsive: services are organised so that they meet people's needs.</p> <p>Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.</p>

Trust Board Report

Trust Strategic Objectives	<ol style="list-style-type: none"> 1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Links to Assurances	Health and Social Care Act (2008): Code of Practice for the Prevention and Control of Infection (2012), Department of Health Guidance and Public Health Guidance.
Resource Implications:	None
Equality and Diversity Impact	
Risks:	<p>Risks of failure to implement policy:</p> <ul style="list-style-type: none"> • Non-compliance with the Health Act 2008 (Hygiene Code 2015)
Risk register reference:	N/A
Other formal bodies involved:	Approval through Infection Prevention and Control Group, and from Wolverhampton City Council Commissioning Group.
References	NICE Quality Standard 61 (2014); EPIC 3 National Evidence based guidelines for the prevention of HCAI in hospitals in England (2014); NICE Prevention and Control of Healthcare Associated infections PHG36 (2011); NICE QS113 Healthcare-associated infections (2016); Collaborative Tuberculosis Strategy for England - 2015 to 2020 (2015); Department of Health; UK 5 year antimicrobial resistance strategy 2013-2018 (2013); Health and Social Care Act (2008): Code of Practice for the Prevention and Control of Infection (2015).

Report Details

1	<p>This strategy will provide an overview of the risks, costs and benefits associated with the prevention and control of infection in Wolverhampton provided through RWT, WCCG and WCC commissioned services and independent healthcare contractors and take a view on nationally and internationally identified risks. Surveillance data and its analysis need to be at the centre of the strategy along with excellent systems of communication.</p> <p>A City-wide Infection Prevention Service (including TB) is supported though funding from:</p> <ul style="list-style-type: none"> • The Royal Wolverhampton NHS Trust, providing services to New Cross, West Park and Cannock Chase Hospitals, vertically integrated (VI) GP practices. • Wolverhampton CCG, for services to independent contractors and to ensure quality to Wolverhampton residents and commissioned providers. • Wolverhampton City Council Public Health Department, for services to care homes, very sheltered housing, Wolverhampton wide surveillance and investigation of HCAI and the TB nursing service.
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Document Control – Strategy Template

<p>Strategy Name: ST02 Infection Prevention Strategy 2019-2022</p>	<p>Version: V4 March 2019</p>	<p>Status: FINAL</p>	<p>Author: Matthew Reid, Head of Nursing - Corporate Support Services Dr J Macve, Director of Infection Prevention and Control Director Sponsor: Ann-Marie Cannaby, Chief Nursing Officer In collaboration with: Sally Roberts, Chief Nurse and Director of Quality, WCCG John Denley, Director of Public Health WCC</p>	
<p>Version / Amendment History</p>	<p>Version</p>	<p>Date</p>	<p>Author</p>	<p>Reason</p>
	<p>1</p>	<p>2006</p>	<p>V Whatley/M Cooper</p>	<p>New strategy</p>
	<p>2</p>	<p>2009</p>	<p>Vanessa Whatley/M Cooper</p>	<p>Strategy delivered</p>
	<p>3</p>	<p>July 2014</p>	<p>V Whatley/M Cooper</p>	<p>Strategy delivered</p>
	<p>4</p>	<p>February 2017</p>	<p>V Whatley/M Cooper</p>	<p>Strategy delivered</p>
<p>5</p>	<p>March 2019</p>	<p>M Reid/J Macve</p>	<p>Strategy renewed</p>	
<p>Intended Recipients: NHS employed health care staff in Wolverhampton, Independent contractors of healthcare in Wolverhampton</p>				

Consultation Group / Role titles and Date: RWT Infection Prevention and Control Group (IPCG), WCCG Quality and Safety Committee	
Name and date of Trust level committee where reviewed	Infection Prevention and Control Group (February 2018)
Name and date of final approval committee	Trust Management Committee March 2019
Date of Policy issue	
Review Date and Frequency [standard review frequency is 3 yearly unless otherwise indicated]	April 2022
Training and Dissemination: Trust Induction and Mandatory training, Trust intranet.	
To be read in conjunction with: Infection Prevention and Control Policies, national guidance relating to infection prevention and control, national directives and CCG quality premium.	
Equality Impact [initial] Assessment [all policies]:	Completed Yes / No
Full Equality Impact assessment [as required]:	Completed Yes / No / NA
<u>If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.</u>	

Contact for Review	Head of Nursing – Corporate Support Services, RWT
Implementation plan / arrangements [Title of Implementation Lead]	Head of Nursing – Corporate Support Services, RWT
Monitoring arrangements and Committee	Infection Prevention and Control Group/WCCG Quality and Safety Group
<p>Document summary / key issues covered:</p> <p>The overall aim of this strategy is to deliver harm free care for those accessing NHS or commissioned health care in Wolverhampton. It is aimed at supporting 3 domains of the NHS outcomes framework:</p> <ul style="list-style-type: none"> • Preventing people from dying prematurely • Ensuring that people have a positive experience of healthcare • Treating and caring for people in a safe environment and protecting them from avoidable harm. <p>The strategy will provide an overview of the risks, costs and benefits associated with the prevention and control of infection in Wolverhampton including The Royal Wolverhampton NHS Trust (RWT), independent contractors of health and social care contracted to Wolverhampton Clinical Commissioning Group (WCCG) or Wolverhampton City Council (WCC) and the wider Wolverhampton health and social care community and taking a view on nationally and internationally identified risks. It will be considerate of emerging and unknown organisms and infections which may arise, of national priorities and drivers and of the information communication and technological revolution. It will therefore ensure that systematic review of existing and future working practices are highly efficient and are integrated into a safe governance infrastructure with effective surveillance data and its analysis at its core along with excellent systems of communication.</p>	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

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Infection Prevention Strategy

1.0 Introduction

The prevention of avoidable infection is central to ensuring safe care and efficiency of healthcare services in the modern NHS, social care and in the private/charitable healthcare sector. The changing landscape of healthcare and social care delivery and monitoring and regulation requires the development of new systems of communication to ensure that infections are managed effectively, involving acute, community, primary and social care delivery in a variety of settings. Preventing healthcare associated infection (HCAI) and its transmission has now been recognised as a system wide need without boundaries¹. Wolverhampton has moved a considerable way towards such a model, however this strategy will provide direction as more opportunities develop with the advent of new models of primary care delivery, accountable care systems and commissioning arrangements for social services.

Since 2006 Wolverhampton has developed an excellent reputation nationally and internationally for the prevention of infection though using a coordinated approach across the City. The Wolverhampton Health Economy has achieved the following outcomes to date:

- More than 60% reduction in MSSA bacteraemia since 2006- 2012;
- Whole Wolverhampton periods without an MRSA bacteraemia of >1 year
- RWT periods without an MRSA bacteraemia of >3 years
- Annual new cases of MRSA acquisition across the city halving since 2006 (>700 cases in 2006 <350 in 2016);
- MRSA colonisation in care homes reduced from 9% of residents to less than 2%^{2,3}
- A 7 fold fall in cases of *C. difficile*;
- A 63% reduction in blood stream infections in RWT due to medical devices 2009-2016;
- ≤2 admissions/year to New Cross Hospital due to norovirus-related dehydration from residential or nursing care homes since winter 2010/11 and 5 years of zero 2011/12-2015/16;
- 80% of people who are found to be colonised with MRSA decolonised successfully.

A City-wide approach is further enhanced with the amalgamation of community and acute services in 2011 and the subsequent service level agreement ensured independent contractors and care facilities have equality of infection prevention service. The joint working that has evolved has led to improved patient safety throughout the entire patient journey, significant progress in the achievement of national objectives, reductions in the impact of outbreaks such as norovirus and flu, learning from incidents and has enabled multiple innovations and new ways of working. This model has since been a recommendation in Lord O'Neil's report 'Infection Prevention, Control and Surveillance: Limiting the Development and Spread of Drug Resistance' (2016) stating "a system-wide focus needs to be placed on prevention (of infection) if we are to tackle AMR." (p:1) though few areas in England offer this.

MSSA bacteraemia has reduced by over 60% across the city, the Royal Wolverhampton NHS Trust has undergone several years at a time without a case of MRSA bacteraemia. The 027 strain of *C. difficile* is no longer endemic in the inpatient setting and levels of *C. difficile* have fallen more than 7-fold despite the introduction of 2-stage testing, with all-cause mortality at 30 days falling below the nationally published average of 15.1%⁴. Finally, MRSA acquisition has fallen to sustained low levels since 2013/14.

Challenges still remain. The vision of no avoidable healthcare associated infection needs to be considered in its broadest terms in an organisation responsible for the delivery of care across the Health Economy. Catheter associated urinary tract infection, gram negative bacteraemia, community-acquired device related blood stream infections, wound infection and ventilator associated pneumonia are all areas where surveillance continues to evolve in order to effect practice. Research and innovation is urgently needed to further understand the impact of interventions, a concept supported by reports by NICE, the National Audit Office and Parliamentary Accounts Committee (NICE 2014; NAO 2009; PAC 2009) but also to understand further the risk in community settings; care homes and patients own homes. Relationships with other healthcare providers in the area need to be strengthened and developed in order to maximise safety for all those accessing health and social care, in whatever setting and standards consistently presented and challenged through strong commissioning processes.

Globally the emergence of new, and re-emergence of historical, organisms and infectious diseases and the potential for bioterrorism presents challenges. The emergence of the H1N1 influenza in 2009, Ebola in West Africa in 2014 and *Mycobacterium Chimaera* in 2015, highlight the need for vigilance and preparedness and for timely information, education and robust and consistent policies from international to health economy levels.

The emergence of new organisms and patterns of resistance is tightly linked to the control and use of antimicrobials with a second 5 year strategy being published by NHS England in 2018 to support essential and appropriate use of these important agents and prevent or slow emergence of organisms such as Carbapenemase-producing Enterobacteriaceae.

2.0 Aim / Objectives

The overall aim of this strategy is to deliver harm free care for those accessing health care in Wolverhampton. It is aimed at supporting 3 domains of the NHS outcomes framework:

- Preventing people from dying prematurely
- Ensuring that people have a positive experience of healthcare
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The strategy will provide an overview of the risks, costs and benefits associated with the prevention and control of infection in Wolverhampton including The Royal Wolverhampton NHS Trust (RWT), independent contractors contracted to Wolverhampton Clinical Commissioning Group (WCCG) and the wider Wolverhampton healthcare community and take a view on nationally and internationally identified risks alongside The Wolverhampton City Council (WCC) Public Health Team. It will be considerate of emerging and unknown organisms and infections which may arise, of national priorities, new models of care and drivers and of the information communication and technological revolution. It will therefore ensure that systematic review of existing and future working practices are highly efficient and are integrated into a safe governance infrastructure with effective surveillance data and its analysis at its core along with excellent systems of communication. Ten strategic objectives have been developed to support this ambition:

- Wolverhampton will continue to grow its reputation as a centre of excellence for infection prevention nationally and internationally and maximise the benefits of working.
- Wolverhampton will be a lead city for research, development and innovation in infection prevention linking with academic institutions, industry and the Department of Health whenever possible to fund further development.
- There will be no avoidable blood stream infection.
- Wolverhampton will build on its robust surgical site infection surveillance to further to establish the irreducible minimum.
- The risk of emerging multi-resistant organisms will be minimised.
- *C. difficile* infection will be reduced to an irreducible minimum and the actions necessary to sustain this fully understood.
- Health and social care systems will work jointly to identify and reduce the risk of spread of tuberculosis.
- The risk of outbreaks will be reduced to a minimum and subsequent organisational disruption through local surveillance and detection of organisms and alert conditions.
- The Code of Practice is fully implemented and monitored within RWT and independent contractors are supported to implement and monitor where relevant.
- Education will be available to health and social care staff, patients, visitors and the general public ensuring that opportunities for income generation are fully realised.

3.0 Scope

The following statement is provided by the National Institute for Health and Clinical Excellence (NICE) to explain a healthcare associated infection.

“Healthcare-associated infections (HCAs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.

The term HCAI covers a wide range of infections. The most well-known include those caused by meticillin-resistant Staphylococcus aureus (MRSA), meticillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) and Escherichia coli (E. coli). HCAs cover any infection contracted:

- *As a direct result of treatment in, or contact with, a health or social care setting*
- *As a result of healthcare delivered in the community*
- *Outside a healthcare setting (for example, in the community) and brought in by patients, staff or visitors and transmitted to others (for example, norovirus).”* (NICE 2011)

The Care Quality Commission regulate all NHS provider services, dentists, out of hours services, care homes and Primary Care services and apply assessment against The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health 2009).

This strategy fully acknowledges the risk of emerging organisms and those not currently identified.

4.0 Strategic Context / Background

This strategy will provide an overview of the risks, costs and benefits associated with the prevention and control of infection in Wolverhampton provided through RWT, WCCG and WCC commissioned services and independent healthcare contractors and take a view on nationally and internationally identified risks. It will be considerate of the information communication and technological revolution and ensure that systematic review of existing and future working practices are highly efficient and are integrated into a safe governance infrastructure.

Surveillance data and its analysis need to be at the centre of the strategy along with excellent systems of communication.

A City-wide Infection Prevention Service (including TB) is supported though funding from:

- The Royal Wolverhampton NHS Trust, providing services to New Cross, West Park and Cannock Chase Hospitals, vertically integrated (VI) GP practices.
- Wolverhampton CCG, for services to independent contractors and to ensure quality to Wolverhampton residents and commissioned providers.
- Wolverhampton City Council Public Health Department, for services to care homes, very sheltered housing, Wolverhampton wide surveillance and investigation of HCAI and the TB nursing service.

5.0 Communication of Strategy

The strategy will be placed on the RWT and Wolverhampton WCCG intranet sites and available to Public Health. It will be shared at Health Economy events as required.

Updates will be provided at least quarterly at the Trust Infection Prevention and Control Group and the WCCG Safety and Quality Committee and Clinical Quality Review Group (CQRM).

6.0 Structure and Approach

6.1 Strengths Weaknesses, Threats and Opportunities Analysis

A SWOT analysis was undertaken to identify the current risks and opportunities for managing them.

STRENGTHS	WEAKNESSES
<p>Wolverhampton has received national recognition (2009, 2011 and 2013) for the prevention of infections with a history of success resulting in national influence. The cohesive “one-city” Team approach is the result of a long standing partnership working involving sharing practices with NHS and independent</p>	<p>There is little published evaluation to date on the effectiveness of the Wolverhampton model for the prevention of infection.</p> <p>To date there is little public engagement</p> <p>Financial challenges across health, public</p>

<p>healthcare services.</p> <p>There is high level Board and Executive support and engagement to reduce HCAI in NHS organisations across the City and from the Public Health Team.</p> <p>RWT is a combined acute and community Trust with vertically integrated GP practices.</p> <p>Current nationally monitored infections are low in Wolverhampton allowing focus on emerging threats and continuous quality improvement.</p> <p>There are excellent relationships between the Infection Prevention Team, GPs and Care home owners/managers.</p> <p>There is a shared ambition and culture of success and patient safety with tried and tested systems to expedite, monitor and manage improvement.</p> <p>The Infection Prevention Team is highly skilled with a breadth of healthcare knowledge including dental, surveillance analysis and interpretation, care services, acute and community healthcare.</p> <p>There is a culture of innovation within the Infection Prevention Team.</p> <p>Leadership roles have been developed within the Team and are effective.</p> <p>The Infection Prevention Team is cohesive and has strong links to other relevant services, including Continence Care, IV, Domestic and Tissue Viability Services, and external agencies, care homes, dental practitioners, GP staff.</p> <p>The IP Team structure supports high productivity against the current expectations, with TB team integration.</p> <p>Surveillance systems for IV device related infections and surgical site infections are ahead of most other health economies.</p> <p>There is a high level of ownership throughout the RWT and the care home sector. Established working relationships with</p>	<p>health and social care threaten repeating past mistakes.</p> <p>Not all infections are capable of healthcare spread are therefore, not currently surveyed.</p> <p>There is no control of the decontamination of community equipment supplied by organisations outside of the NHS.</p> <p>There is limited control or influence over local private providers of healthcare e.g. BUPA, Compton Hospice, Nuffield Healthcare.</p> <p>There is no control of care agency staff providing hands on care to Wolverhampton residents in their own homes.</p> <p>Since national reorganisation of the NHS there is no Health Economy forum for prevention of HCAI.</p> <p>WCCG and Public Health as part of local authorities are still in their infancy. Electronic prescribing roll-out.</p>
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<p>Wolverhampton University.</p> <p>IP education and outbreak management is funded through public health to all residential care services including Very Sheltered Housing.</p> <p>New purpose-built on-site Microbiology Laboratory expanding testing capabilities including Flu, norovirus TB and Carbapenemase-producing Enterobacteriaceae (CPE).</p>	
OPPORTUNITIES	THREATS
<p>The integration of the TB nursing service into the IP Team.</p> <p>The Head of Nursing role enables a strategic approach to IP Team development, expansion of local projects and engagement in national projects.</p> <p>The development of accountable-care systems including the vertical integration of some GP practices.</p> <p>Further expansion of the City-wide approach to infection prevention to encompass prophylactic treatment (e.g. flu).</p> <p>Further development of the Infection Prevention/TB Team to encompass wider skills and knowledge.</p> <p>National political interest in prevention of HCAI.</p> <p>The Mandate to the NHS Commissioning Board supports the reduction of HCAI but is currently not prescriptive in the delivery other than historically monitored infections.</p> <p>Build on support and successes in joint working with WCCG and Public Health.</p> <p>Through pathology modernisation there are opportunities for new ways of working, partnership with other trusts and growth of our business across geographical boundaries.</p> <p>There are multiple opportunities for collaboration in research, development and publishing.</p>	<p>Unforeseen outbreaks and incidents.</p> <p>Changes to the personnel in the Infection Prevention Team resulting in a loss of relationships particularly with GP and Care home staff.</p> <p>The emergence of new organisms and conditions.</p> <p>There is political uncertainty in the healthcare environment, the role that Infection Prevention will have in the achievement of performance criteria and where it will be placed from a commissioning perspective in the next term of government.</p> <p>There is a potential for further changes to the commissioning structure in a new term of government.</p> <p>Patient choice could influence financial feasibility of the team and the organisations ability to deliver multiple challenges.</p> <p>The potential fragmentation of emergency planning and national surveillance pathways with the formation of Public Health England could result in missed communications/actions to prevent infection.</p> <p>Internal reorganisations could result in energy being directed away from patient safety 'eye off the ball'.</p> <p>The current financial environment could lead to significant cuts in the 'proactive' approach to preventing infection. Maintaining the focus on patient safety versus financial challenges</p>

<p>Collaborative working with the Health and Wellbeing Board, CQC, other CCG's and the National Commissioning Board.</p> <p>Further develop accuracy and efficiency in the handing of information and expansion of data collection and analysis to inform best practice and anticipate threats to business and patient safety through the digital age.</p> <p>Expansion of OPAT services to admission avoidance of patients with infections.</p> <p>Expansion of the Trusts Laboratory services to the Black Country Network.</p> <p>Prevalence of infection in care homes completed.</p>	<p>remains challenging.</p> <p>Changes in leadership at Board Level/CCG/Director of Public Health.</p>
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6.2 PESTLE Analysis

Political	<p>Strengthening of patient choice: 'No decision about me without me.'</p> <p>Change in the organisation of health and social care.</p> <p>Outcome of MSFT report.</p> <p>Infection rates, mandatory surveillance data, standards of cleanliness, surgical infection rates, quality assurance data regarding infection prevention and control are increasingly in the public domain.</p> <p>The specific Government performance measurements relating to infection prevention and control that Trusts and CCG's are monitored on and held to account for are changing.</p> <p>The National Commissioning Board (NCB) replaced SHAs and has been set a mandate by NHS England to improve a number of areas including patient experience, Enhancing quality of life for people with long term conditions, helping people recover from illness or injury, preventing avoidable harm and encouraging innovation.</p> <p>CCGs are working increasingly with Local Authority and NCB.</p> <p>National directive to reduce healthcare associated gram negative bacteraemia by 50% by 2021.</p> <p>Impact of Lord Carter of Cole's review of Pathology Services on the delivery of local microbiology services is still to be fully realised.</p> <p>Monitoring / inspection of the Code of Practice for HCAI by the Care Quality Commission acting as the regulator.</p> <p>Change of emphasis by the Care Quality Commission as their inspection regime becomes more in line with other similar agencies such as OFSTED.</p> <p>Increased NHSI interest through previous success.</p>
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Securing Foundation Trust Status.

Environmental Trust Executive: culture engenders staff empowerment, responsibility and leadership at all levels. Innovation, change and challenge are expected.

The Trust's building stock is of varying ages and condition. Potential HCAI risks require risk assessing pending a new hospital build.

GP surgeries of varying ages and state of repair.

A need to fully understand the impact of community acquired infection.

Multiple building/demolition projects on site requiring risk assessment and specialist input.

Reconfiguration of service provision; local delivery of specific services via hubs or at sites other than current location.

Cleaning arrangements – Cleaning Strategy, Environmental Group.

Threat of major pandemic of infectious disease.

Increase in travel tourism and related infections more commonly found internationally.

Anticipated increase in antimicrobial resistance in a range of organisms, presenting challenges for prompt identification, treatment, isolation and patient information.

Cross boarder working and information sharing.

Possible relocation of other Trust's laboratory services to RWT.

Social Socially deprived population, with higher than average rate of tuberculosis, poor nutrition, STDs, teenage pregnancy, asylum seekers, obesity, diabetes and alcoholism.

An ageing population and workforce who are experiencing a greater number of healthcare related events.

High incidence of TB in Wolverhampton.

Increasing public expectation of healthcare services.

Increasing demand on urgent care services.

Increasing understanding of HCAI by the general public.

More accessible information on the Internet.

Technological Rapid results reporting [2 hour test for MRSA], on site norovirus testing, PCR testing for *Clostridium difficile* and influenza.

The relocation of the laboratory to modern facilities and equipment.

Electronic patient record.

Electronic prescribing.

Safe Hands.

Electronic Ward Ordering systems.

Electronic surveillance packages. (ICNet)

Electronic observations.

	Electronic pathology requesting.
	Electronic audit systems.
	Increasing medical technological advances leading to more complicated means of reprocessing equipment.
	Post discharge surveillance.
	Drive to move to paperless systems of work.
	Access to more sensitive and specific typing methods, including whole genome sequencing.
Legal	Updated and New EU Health & Safety and related legislation e.g. waste regulations and safe sharps carry a financial burden.
	Increasing regulation and review of healthcare: compliance with the Health Act.
	Number of complaints and litigation citing HCAI and environmental cleanliness increasing nationally.
	Increase in coroners enquires relating to HCAI.
	Health and Safety Executive recommendations/actions on safe sharps.
	Increasing requests for HCAI related data under the Freedom of Information Act.
Economic	Mori Poll indicates that infection rates will influence patient choice, which, through Payment by Results (PBR), will adversely affect income.
	Costs of HCAI need to be further understood at a local level.
	Emerging Infectious diseases and natural disasters affecting the world economy (e.g. SARS wiped an estimated \$12 billion off the economies of the Far East).
	Bioterrorism and natural disasters affecting the ability of affected countries to provide goods and services.
	The current UK economic climate means that public service funding is unlikely to increase in the term of this strategy.
	Systems to fully understand the cost-benefit of preventing infection need to be put in place.

6.3 Milestones

2019/20

At least one publication in a peer reviewed journal.

90% of catheters monitored on VitalPAC. Monthly urinary catheters usage (total number of catheters) reduced by 10%. 10% decrease in the average duration of urinary catheters in acute setting (all data to be available from Vital pacs system). 50% of patients discharged with a catheter have a catheter plan.

The proportion of the population with long term urinary catheterisation will be reduced by 5%.

Implement catheter reduction project in community services (VI Practices).

Develop process of surveillance for catheter associated urinary tract infection (CAUTI) and obtain baseline.

Sustainable definition and surveillance on community related bacteraemia (C-DRB).

Obtain baseline hospital acquired pneumonia data.

Reduce Trust surgical site infection (SSI) rate by 0.25% (based on in-patient, readmission and post discharge identified SSI, cumulative 12 month SSI rate).

A locally run IP focused national conference or course will be scoped and run.

Latent TB screening project continues, $\geq 50\%$ in numbers screened from 2018/19 data. >30 Wolverhampton residents identified with latent TB. Successful securing of TB nursing service contract for next 3-5 years.

Device-related hospital acquired bacteraemia (DRHAB) < 4 per month.

MRSA screening in portals 90% compliant. Trust acquisitions of MRSA ≤ 2 per month.

Undertake audit to ascertain CPE screening compliance.

Identify strategies to reduce cases of hospital acquired pneumonia.

VI GP surgery quality assurance audit scores will demonstrate improvement.

Achieve environmental audit compliance of 95%.

<p>2020/21</p>	<p>DRHAB < 2.5 per month.</p> <p>10% reduction in CAUTI from baseline.</p> <p>Further 5% reduction in number of catheters per month from baseline.</p> <p>20% decrease in the duration of urinary catheters from baseline.</p> <p>60% of patients discharged with a catheter have a catheter plan.</p> <p>Undertake audit to ascertain CPE screening compliance. Screening compliance to increase by 10 percentage points from 2018/19 audit data.</p> <p>MRSA screening in portals 95% compliant.</p> <p>Trust acquisitions of MRSA sustained at ≤ 2 per month.</p> <p>Implement strategies to reduce cases of hospital acquired pneumonia.</p> <p>External engagement in national projects/R&D programmes will be achieved.</p> <p>50% reduction in HCAI related gram negative bacteraemia.</p> <p>NHS organisations in Wolverhampton meeting nationally specified outcomes in relation to IP.</p> <p>Maintain a compliance of 95% against environmental audits.</p> <p>Engage in an externally funded Infection Prevention related research study and publish findings in international peer reviewed journal.</p> <p>A locally run IP focused national conference or course will be scoped and run.</p>
<p>2021/22</p>	<p>DRHAB < 2 per month.</p> <p>95% compliance for MRSA screening in portals sustained.</p> <p>Trust acquisitions of MRSA sustained at ≤ 2 per month.</p> <p>Audit CPE screening compliance. Screening compliance to increase by 10 percentage points from 2020/21 audit data.</p> <p>70% of patients discharged with a catheter have a catheter plan.</p> <p>Maintain a compliance of 95% against environmental audits.</p> <p>A locally run IP focused national conference or course will be</p>

	scoped and run.
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7.0 Roles and responsibilities

This section of the strategy identifies the roles and responsibilities of key individuals and committees, highlighting accountability levels at each stage. It provides a brief synopsis of key roles and committees. A more detailed account of individual and committee responsibilities for all levels of the Trust is provided in the Trust’s Infection Prevention Operational Policy.

The RWT Trust Board, managers, matrons and staff are responsible for establishing, maintaining and supporting a co-ordinated approach to infection prevention in all areas of their responsibility. The WCCG and Public Health Team are responsible for ensuring that Infection prevention outcomes are commissioned as part of the quality assurance of commissioned services and promoted to GP, local-authority and dental partners.

This includes incorporating infection prevention and control advice and guidance into local policy and practice developments. Risks also need to be identified and relevant assurance given through registering on the appropriate risk register and regular monitoring.

7.1 Individual Responsibilities - RWT:

Chief Executive

The Chief Executive accepts on behalf of the Trust Board ultimate responsibility for all aspects of Infection Prevention within the Trust. This responsibility is delegated to the Chief Nurse.

Chief Nursing Officer

Has lead executive director responsibility for infection prevention and will delegate local operational responsibility to Heads of Nursing, Matrons and ward / Department Managers. The Chief Nurse works in close collaboration with the Director of Infection Prevention and Control (DIPC) and Head of Nursing for Corporate Support Services, incorporating national guidance into local policy, monitoring key performance indicators (KPIs) and compliance with the Infection Prevention and Control Annual Plan, reporting directly to the Trust Board.

Chief Operating Officer

Has responsibility for the Trust performance framework and will delegate local operational responsibility for performance aspects of the strategy to Clinical Directors via the Divisional Directors.

Medical Director

Will oversee implementation of the strategy within all Trust services and will delegate local operational responsibility to Clinical Directors via the Divisional Medical Directors. The Medical Director Chairs the Infection Prevention and Control Group.

Director of Workforce and Organisational Development

Will ensure that all Trust staff job descriptions contain explicit reference to infection prevention and where appropriate Occupational Health policies and procedures support the Infection Prevention Strategy.

Finance Director

Will ensure that resources are available centrally to finance the management and control of outbreaks of infection. They will also work collaboratively with the Lead Nurse and DIPC to establish costs of HCAI as part of the remit for clinical engagement.

Director of Estates and Development / Facilities Manager

These roles will ensure the environment is suitably planned and maintained to support the implementation of the Infection Prevention Strategy.

Director of Infection Prevention and Control

Has lead director responsibility for Infection Prevention and Control and will delegate operational responsibility. The DIPC will lead, and be accountable for, the review and communication of the strategy, assessment of milestones and ensure that appropriate planning takes place in order to deliver the strategy.

Head of Nursing – Corporate Support Services

Will jointly review the strategy with the DIPC. This role provides key leadership for the team, in particular project leads and the Operational Nurse Manager, holds budgetary responsibility, is responsible for coordinating income generation, maintaining good relationships within the Health Economy and nationally, external promotion of the team and its capabilities. The role is responsible for additional teams whose specialty will benefit from a similar model of delivery to Infection Prevention at the discretion of the Chief Nurse.

Operational Nurse Manager - Infection Prevention

Has responsibility for the operational management of the Infection Prevention Strategy within the Trust and the on-going development and evaluation of communication strategies at Trust and Divisional levels aimed at the facilitation of infection prevention policies, guidance and practice and delivery of the annual programme of work.

Infection Prevention Nurses

Responsible for supporting divisional activity in relation to infection prevention, providing a facilitative service in order to deliver projects, policies and practices delegated to them to support the implementation of the strategy.

Divisional Directors and Clinical Directors

Accountable for local performance management and receipt of key messages for dissemination to clinical teams. Action on HCAI in their area of responsibility including local investigation into outbreaks and incidents. Participation in and leadership of initiatives. In addition regular reporting to the Infection Prevention and Control Group on the implementation and evaluation of infection prevention in their areas of responsibility.

Divisional/General/Group Managers / Divisional Nurses

Responsible for local performance management with regard to infection prevention and control outcome measures, assisting in the development of divisional action plan for infection prevention and ensuring local uptake of infection prevention strategy through regular reporting on the divisional action plans.

Matrons

Responsible for the communication of the strategy within their areas of responsibility and facilitation of systems and processes aimed at meeting the

objectives of the strategy and their relevant divisional action plan. Matrons play a key role in the identification, communication and minimisation of Infection prevention risks through trust agreed processes.

Head of Hotel Services

Responsible for ensuring that suitable systems and processes are in place to maintain environmental cleanliness. Chairs the environmental sub-committee of the IPCG.

Local Area Managers

Responsible for ensuring that systems and processes are in place to monitor and prevent infection and ensure that infection prevention is included in all revised job descriptions and appraisals. Responsible for ensuring their ward or area is kept clean and tidy and that good lines of communication from the ward to the team are maintained including the allocation of link nurses practitioners.

Link Personnel

Responsible for setting a good example of infection prevention practice, challenging poor practice, regular communication with the local area manager on matters relating to infection prevention and involvement in the roll out of infection prevention initiatives locally.

All Staff members

All staff members are responsible for compliance with infection prevention policies and procedures and providing the highest standards of clinical practice. They are responsible for acting on and reporting poor practice.

Patient Communications/Engagement leads

Responsible for facilitating appropriate opportunities for patient and public engagement with infection prevention and control public health messages and opportunities to engage the public in infection prevention initiatives.

7.2 Individual responsibilities – WCCG

Executive Nurse CCG

Holds responsibility for the relevant inclusion of infection prevention standards in CCG-commissioned services supports the 'one-city' approach and highlights areas of risk requiring joint work to ensure the NHS mandate is achieved.

7.3 Individual responsibilities – WCC

Director of Public Health

Jointly, with CCG, and DIPC/Head of Nursing leads on identification of community HCAI/infection risks which will benefit from joint working. Uses links with Public Health England to inform levels of risk and help the DIPC/Head of Nursing prioritise strategic and operational objectives. Sits on RWT Infection Prevention and Control Group.

7.4 Committee Responsibilities

Trust Board

The Trust Board is responsible for ensuring that the Trust has appropriate infection prevention and control systems and resources in place to enable the organisation to

deliver its objectives and statutory requirements. The Trust Board receives and formally approves the Trust Infection Prevention Strategy and the Director of Infection Prevention and Control's Annual Report.

Trust Management Committee

Receives and endorses the Infection Prevention Strategy and policies and reviews compliance with the strategy through the reporting of monthly Infection Prevention key performance indicators and through reviewing local performance outcome measures via the performance framework leads.

Trust Quality Safety Intelligence Group

Receives and monitors key performance indicator reports, highlights any areas of concern and supports compliance with the strategy through local governance structures and processes.

Infection Prevention and Control Group

Receives reports from the RWT Divisions on their progress with uptake of the strategy, debates and directs future strategy.

Quality and Safety Committee (WCCG)

Receives and monitors key performance indicator reports, highlights any areas of concern and supports compliance with the strategy through local governance structures and processes for those contracting with the CCG.

Clinical Quality Review Group (CQRG)

Receives and monitors performance for clinical quality aspects of provider contracts.

8.0 Equality statement

The initial screening of this policy has not identified any adverse/negative impact and therefore a full equality impact assessment is not required.

9.0 Evaluation and Review

The RWT IPCG will monitor annually against milestones.

The WCCG Quality and Safety Committee will receive annual update against the milestones.

10.0 Resource assessment

Describe all resource requirements or dependencies of the strategy e.g. finance people and time resource. Please refer table below and retain all yes content in the final strategy.

1	Does the implementation of this policy require any additional Capital resources	Yes – No
2	Does the implementation of this policy require additional revenue resources	Yes – No
3	Does the implementation of this policy require additional manpower	Yes – No
4	Does the implementation of this policy release any	Yes – No

	manpower costs through a change in practice	
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	Yes – No
	Other comments	

11.0 References

Source of data	Date of publication / issue	Detail of requirement
NICE Quality Standard 61	April 2014	Prevention and control of infection for people receiving healthcare in primary, community and secondary care settings.
Everyone Counts : Planning for patients 2014/15-2018/19	December 2013	Five year strategic plan to secure high quality care now and for future generations.
EPIC 3 National Evidence based guidelines for the prevention of HCAI in hospitals in England	January 2014	Guidance to prevent infection in acute healthcare services
NICE Prevention and Control of Healthcare Associated infections PHG36	2011	Guidance to prevent infection in community healthcare provision.
Code of Practice for HCAI	December 2010	Minimum requirements assessed by CQC during routine inspection of healthcare providers to maintain registration.
Department of Health; UK 5 year antimicrobial resistance strategy 2013-2018	2013	Five year strategic plan to
Clostridium difficile infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation	2014	Reporting and detection of avoidable cases of C. difficile.
Thirty-day all-cause fatality subsequent to MRSA, MSSA, and E. coli bacteraemia and	2017	PHE

C. difficile infection		
Tackling infection in care homes. Nursing Times; 108: 7, 16-18.	2012	Winfield J, Wiley C.
Reduction in methicillin-resistant Staphylococcus aureus colonisation: impact of a screening and decolonisation programme. Journal of Infection Prevention, 17(6), pp.294-297.	2016	Garvey, M.I., Winfield, J., Wiley, C., Reid, M. and Cooper, M.
Collaborative Tuberculosis Strategy for England - 2015 to 2020	2015	The collaborative TB strategy brings together best practice in clinical care, social support and public health to strengthen TB control, with the aim of achieving a year-on-year decrease in incidence, a reduction in health inequalities and, ultimately, the elimination of TB as a public health problem in England.